Perinatal Hepatitis B Case Report Form

Georgia Department of Public Health

Please complete form for infants exposed to hepatitis B at birth and fax copy to DPH.

MOTHER

Name:_____ DOB:_____

Street Address:_____

City:_____ State:_____ Zip:_____

HBsAg Collection Date:_____ Result: ☐ Reactive ☐ Negative ☐ Indeterminate

INFANT

Name:_____ DOB:_____

Time of Birth:_____ Birth Weight:_____ Gender: ☐ Male ☐ Female

Hepatitis B Immune Globulin (HBIG) ☐ Administered ☐ Not Administered

HBIG Administration Date:_____ HBIG Administration Time:_____

HBIG Brand Name: ☐ HyperHEP B ☐ Nabi-HB Entered into GRITS: ☐ Yes ☐ No

Hepatitis B Vaccine (HepB) ☐ Administered ☐ Not Administered

HepB Administration Date:_____ HepB Administration Time:_____

HepB Brand Name: ☐ Engerix-B ☐ Recombivax-HB Entered into GRITS: ☐ Yes ☐ No

DELIVERY HOSPITAL

Hospital Name:_____

Contact Person:_____ Phone:_____

FAX COMPLETED FORM TO 404-657-6871

Georgia Perinatal Hepatitis B Prevention Program
2 Peachtree St. NW, Suite 14-263 ◆ Atlanta, GA 30303
Phone: 404-651-5196 ◆ Website: dph.ga.gov/perinatal-hepatitis-b